Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PINE CREEK MEDICAL CENTER
9032 HARRY HINES BLVD
DALLAS TX 75235

Respondent Name
CHARTER OAK FIRE INSURANCE CO

Carrier's Austin Representative Box
#05

MFDR Tracking Number
M4-10-3677-01

MFDR Date Received
APRIL 19, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier/TPA failed to properly notify the HCP of any contractual agreement between carrier/TPA and the informal and voluntary network, as required by TDI-DWC Rule 133.4, therefore carrier/TPA is not entitled to any network discounts and the claim should be reimbursed in accordance with TDI-DWC §134.404..."

Amount in Dispute: $28,052.92

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider's Request for Medical Fee Dispute Resolution involves reimbursement for an inpatient hospital facility fee. The Provider submitted a bill for the facility portion of services rendered on in October of 2009 for a lumbar laminectomy, DRG 455. The Provider submitted billing in the amount of $221,858.66, including $159,060.00 for implantables. The Carrier initially reimbursed the Provider $33,962.63 on the admission, and an additional $33,812.00 for the implantables. The Carrier then reduced the bill pursuant to the Aetna contract with the Provider, resulting in a total reimbursement of $35,932.00…The Provider was properly reimbursed based on the terms of the contact between the Carrier and the Provider through the Carrier's medical contract vendor, Aetna…The Provider has already been reimbursed in full pursuant to Rule 134.403(e)(1), which states the reimbursement shall be the amount specified by the contract between the provider and carrier. The Provider is not entitled to additional reimbursement pursuant to the terms of the contract…the Carrier contends the Provider is not entitled to additional reimbursement…"

Response Submitted by: Travelers, 11501 S. Mopac Expressway, Suite A320, Austin, TX 78746

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 29, 2009 Through October 31, 2009	Inpatient Hospital Surgical Services	$28,052.92	$28,052.92

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated December 21, 2009
   - DPAY — W1 — WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT. RE-PRICED IN ACCORDANCE WITH THE DRG RATE.
   - INCG — W1 — WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT. RE-PRICING INCLUDED IN THE DRG RATE.
   - FEES — W1 — WORKERS COMPENSATION STATE F/S/ ADJ. REIMBURSEMENT BASED ON MAX ALLOWABLE FEE FOR THIS PROC. BASED ON MEDICAL F/S, OR IF ON IS NOT SPECIFIED, UCR FOR THIS ZIP CODE AREA.
   - F03B — 131 — CLAIM SPECIFIC NEGOTIATED DISCOUNT. ANY REDUCTION IS IN ACCORDANCE WITH FOCUS/AETNA WORKERS COMP ACCESS LLC. FOR QUESTIONS REGARDING NETWORK REDUCTIONS, PLEASE CALL 1-800-243-2336.

   Explanation of benefits dated January 11, 2010
   - W1 — WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT. RE-PRICED IN ACCORDANCE WITH THE DRG RATE.
   - W1 — WORK COMP STATE FEE SCHEDULE ADJUSTMENT. THE SUBMITTED SERVICES ARE CURRENTLY BEING REVIEWED BY YOUR PPO NETWORK. PLEASE ALLOW ADDITIONAL TIME.
   - W1 — WORKERS COMPENSATION STATE F/S/ ADJ. REIMBURSEMENT BASED ON MAX ALLOWABLE FEE FOR THIS PROC. BASED ON MEDICAL F/S, OR IF ON IS NOT SPECIFIED, UCR FOR THIS ZIP CODE AREA.
   - 131 — CLAIM SPECIFIC NEGOTIATED DISCOUNT. ANY REDUCTION IS IN ACCORDANCE WITH FOCUS/AETNA WORKERS COMP ACCESS LLC. FOR QUESTIONS REGARDING NETWORK REDUCTIONS, PLEASE CALL 1-800-243-2336.

Issues

1. Was the workers' compensation insurance carrier entitled to pay the health care provider at a contracted rate?
2. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?
3. Which reimbursement calculation applies to the services in dispute?
4. What is the maximum allowable reimbursement for the services in dispute?
5. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. The requestor alleges that the respondent failed to notify it of any "any contractual agreement…as required by TDI/DWC Rule 133.4." Pursuant to 28 TAC §133.4(c), the insurance carrier, or the insurance carrier's agent, as appropriate, shall notify each affected health care provider of any person that is given access to the informal or voluntary network's fee arrangement. The rule under sections (d) and (f) goes on to describe the form, manner, and time-frame by which such notice must be provided. The carrier its response to medical fee dispute states "The Provider has filed multiple Requests for Medical Fee Dispute Resolution on multiple claims…The Provider has been notified of the contract in each instance…and has been contacted by the Carrier's contract vendor to educate them regarding the terms of the contract." Although the carrier alleges that the requestor was notified of a contract as a result of filing medical fee disputes, no documentation was provided to sufficiently support that the carrier provided notice pursuant to 28 TAC §133.4. The actions that the carrier described in its position statement do not constitute notice in accordance with 28 TAC §133.4. Specifically, the carrier failed to support that notice contained the information stated in paragraphs (d)(1), (2)(A) and (2)(B), and it failed to support that that the notice was made timely pursuant to section (f). The division concludes that: (1) pursuant to 28 TAC §133.4 (g), the carrier is not entitled to pay the requestor at a contracted fee; and (2) that the division fee guidelines apply pursuant to 28 TAC §133.4 (h).

2. Applicable 28 Texas Administrative Code §134.404(e) states that: “Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:
   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
   (2) if no contracted fee schedule exists that complies with Labor Code §413.011, **the maximum allowable reimbursement (MAR) amount under subsection (f)** of this section, including any applicable outlier payment amounts and reimbursement for implantables.”

   Because the carrier is not entitled to pay at a contracted rate, §134.404(e)(2) applies. In turn, the MAR can be established under §134.404(f).

3. §134.404(f) states that “The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 143 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent.”

   Review of the documentation finds that that the facility requested separate reimbursement for implantables; for that reason, the requirements of subsection (g) apply.

4. §134.404(g) states, in pertinent part, that “(g) Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission.
   (1) A facility or surgical implant provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual costs (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge."

   Review of the documentation found supports that the following items were certified as required by (g):

Itemized Statement Rev Code or Charge Code	Itemized Statement Description	Cost Invoice Description	# Units & Cost Per Unit	Cost Invoice Amount	***Per item*** Add-on (cost +10% or $1,000 whichever is less).
278	IMP MEDT INFUSE SM	BIOLOGICS 7510200 INFUS BONE GRFT SMKIT	1 at $3,451.00 ea	$3,451.00	$3,796.10
278	IMP OSTEO ORTHOBLEND 5CC	5CC ORTHOBLEND SMALL DEFGRAFTON DBM	1 at $1,040.00 ea	$1,040.00	$1,144.00
278	IMP ISOTIS PUTTY 10CC DBM AV03	ACCELL EVO3 10 CC	1 at $2,000.00 ea	$2,000.00	$2,200.00
278	IMP CPM-MED PUTTY 10CC	H – GENIN PUTTY (10CC)	1 at $3,250.00 ea	$3,250.00	$3,575.00
278	IMP SP-SMITH BONE FUSIONARY	BONE MARROW ASPIRATE CONCENTRATE KIT	1 at $1,995.00 ea	$1,995.00	$2,194.50
278	IMP ISOTIS BONE CHIPS	ALLOGRAFT CANCELLOUS	1 at $265.00	$265.00	$291.50

	15CC	BONE CRUSHED 1-4MM 15CC	ea		
278	IMP NV-SP GRAFT XLIF MAS	MAS – XLIF COROEN XXL – SINGLE ELVEL	1 at $9,831.00 ea	$9,831.00	$10,814.10
278	IMP OSTEO MATRX STRIP 1 X 10CM	8MM X 1CM X 10CM	1 at $1,460.00 ea	$1,460.00	$1,606.00
278	IMP OMNI SCR 6.0 X 45 MM	6.0MM X 45MM REDUCTION SCREW	4 at $1,495.00 ea	$5,980.00	$6,578.00
278	IMP OMNI ROD 5.5 X 35MM	PREBENT ROD 5.5 X 35MM	2 at $400.00 ea	$800.00	$880.00
278	IMP OMNI SET SCR CAP	SET SCREW CAP	4 at $435.00 ea	$1,740.00	$1,914.00

$31,812.00	$33,812.00
Total Supported Cost	**Sum of Per-Item Add-on**

The division finds that the facility supported separate reimbursement for these implantables, and that the cost invoices were certified as required. Therefore, the MAR is calculated according to §134.404(f)(1)(B).

5. §134.404(f)(1)(B) establishes MAR by multiplying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors (including outliers) by 108%, ***plus*** reimbursement for items appropriately certified under §134.404(g). The Medicare IPPS payment rates are found at http://www.cms.gov, and the sum of the per-item add-on for which separate reimbursement was requested are taken from the table above.

   - Documentation found supports that the DRG assigned to the services in dispute is 455, and that the services were provided at Pine Creek Medical Center. Consideration of the DRG, location of the services, and bill-specific information results in a total Medicare facility specific allowable amount of $31,446.88. This amount multiplied by 108% results in an allowable of $33,962.63.
   - The total cost for implantables is $31,812.00. The sum of the per-billed-item add-ons exceeds the $2000 allowed by rule; for that reason, the total allowable amount for implantables is $31,812.00 plus $2,000, which equals $33,812.00.

   Therefore, the total allowable reimbursement for the services in dispute is $33,962.63 plus $33,812.00, which equals $67,774.63. The respondent issued payment in the amount of $35,932.00. Based upon the documentation submitted, and the requestor's *Table of Disputed Services*, additional reimbursement in the amount of $28,052.92 is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections §413.031 and §413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $28,052.92 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		March 21, 2013
Signature	Medical Fee Dispute Resolution Officer	Date
		March 21, 2013
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.